

Adolescent Psychiatry Preadmission and Post Discharge Collaborative Care Program

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- Provide services to children and youth from the province of British Columbia and the Yukon Territory
- Referrals come from the various provincial health care regions, mental health centres (a physician is required to make the referral)



Total # of clients seen April-Sept 2009:

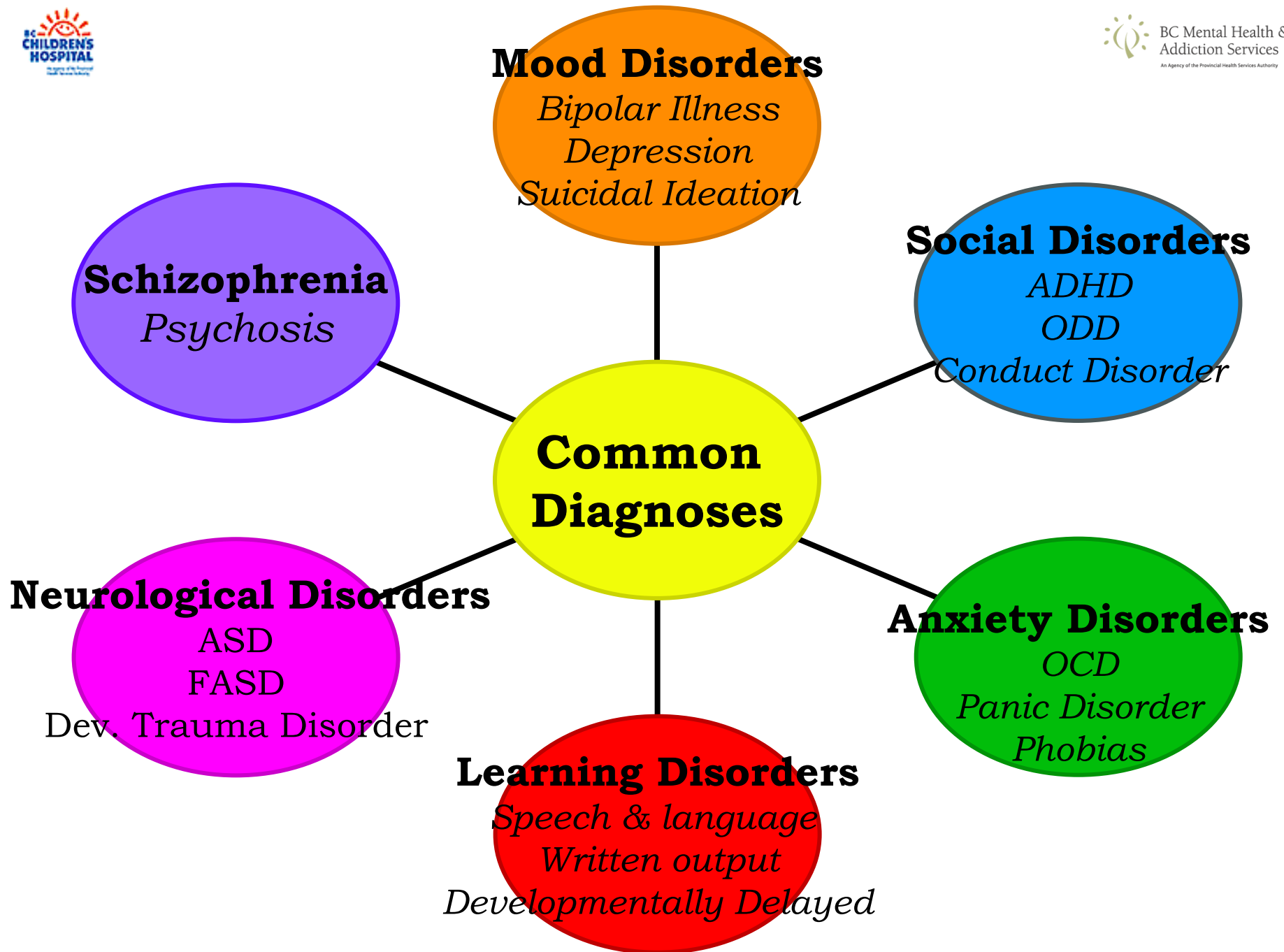
Inpatient units:
~100

Crisis unit:
~250 children &
youth

New Outpatient
visits: 1156

*(does not include Eating
Disorders)*





CHILD Inpatient Unit

- 10 bed unit
- Ages 5-11 years
- Average length of stay:
- 6-8 weeks

Tertiary assessment, short term treatment, social support, teaching, research & discharge planning

Parents/caregivers are encouraged to participate in program activities



CAPE

(Child & Adolescent Psychiatric Emergency)

- Emergency crisis intervention and stabilization unit
- Serves ages 4-16
- 5 – 21 days/ 6 beds

- Admissions must be received from an emergency unit and must first be seen and referred by a psychiatrist, &/or emergency physician



OUTPATIENT DEPARTMENT

- **Attention Deficit Hyperactivity Disorder Program** – Consultation & short-term treatment of children & youth
- **Concurrent Disorders** – Consultation for youth age 14-24 years
- **General Family Teaching** – Consultation & short term treatment/family therapy
- **Infant Psychiatry** – Consultation, assessment & short term treatment from birth to 6th birthday.
- **Mood and Anxiety disorders** – Consultation & group therapy
- **Neuropsychiatry** – Consultation, assessment & short-term treatment
- **Urgent Assessment Clinic** – Provides prompt 1-2 week assessment and consultation for children/youth in acute psychiatric crisis

EATING DISORDERS

- 14 bed Inpatient Unit
- Day treatment program
- Outpatient clinics
- Ages up to 17 years

Inter-professional programming, lifestyle/dietary education, family therapy, and individual therapy



Adolescent Inpatients

- 10 beds
- Average length of stay:
2-6 weeks
- Age 12-17

Tertiary assessment,
short-term treatment,
discharge planning,
teaching, research



Creating a Culture of Non-violence Through The Engagement Model©

- **Trauma Informed**
- **Community & Collaboration**
- **Physical, Emotional & Psychological Safety**
- **Client Centered**
- **The Language of Non-Violence**



Evolutions in Healthcare:
Maggie Bennington-Davis, MD
Tim Murphy, MS

Welcome

- Engagement is reflected in an open and welcoming environment from the moment of first contact (telephone or in person).
- A culture of engagement is supported in all the relationships in an organization & is based on a model of shared governance, respect & collaboration for all members.



Adolescent Psychiatry



Goals:

- Decrease the waitlist and wait times
- Improve health outcomes
- Improve quality of care
- Increase community capacity
- Improve support for the families/caregivers with youth on the waitlist
- Help reduce length of stay

Inter-Professional Team

- Psychiatrists
- Psychologists
- Social Workers
- Registered and Psychiatric Nurses
- Youth and Family Counselors
- Nurse Practitioner
- Occupational Therapists
- Special Education School Teachers



Preadmission

- Collaborative planning with community partners and family
- Outpatient visits and assessments with interdisciplinary team
- Tour of the inpatient unit
- Goal setting
- Calm, cool and collected tool
- Safety Plan

Admissions

- Easier transition from home to inpatient unit
- Decrease in aggression, violence
- Discharge planning booklet
- Therapeutic weekend passes
- Parent group
- Planning and discharge meetings with community partners
- Outreach and liaison back to community



Post – Follow up

- Bridging with community partners
- Follow up testing
- Follow up meetings or phone calls with community partners, caregivers and the youth
- Approximately 3 months

Outcomes

- April 2007-Sept 2009 the Pre-admission team has assessed 120 youth and 80 required inpatient assessment
- Youth directly admitted to the inpatient unit from the crisis unit are followed in the post program
- Increased involvement with community services
- Reduced re-admission rates
- Improved therapeutic rapport creating more opportunity for therapy and education

Unexpected outcomes

- The elimination of physical restraint and /or seclusion of youth with a previous history of acting out behavior
- Feedback from community partners appreciating increased communication and involvement
- Improved relationships with youth and families



Questions?

